Health Information Privacy Complaint Form
-FACT SHEET-

The Military Health System (MHS) Notice of Privacy Practices is provided to beneficiaries as a requirement of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It describes how the MHS may use and disclose your health information, with whom that information may be shared, and the safeguards in place to protect it. It also explains patient rights under the Act. To view the HIPAA Privacy Rule go to: www.hhs.gov/ocr/hipaa/. You may view the MHS Notice of Privacy Practices at www.tricare.osd.mil/hipaa/ or obtain a copy at Naval Healthcare New England. Specific questions about the notice may be directed to 1-888-DOD-HIPA (1-888-363- 4472/TTY 1-877-535-6778) or hipaamail@tma.osd.mil.

If you believe that Naval Healthcare New England or other MHS component has violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule, you may file a written complaint with your local MTF HIPAA Privacy Officer. If you feel the issue has not been, or cannot be appropriately addressed at the MTF level you may file a complaint with the TRICARE Management Activity (TMA) Privacy Office. You also have the right to make inquiries or address complaints directly to the Department of Health and Human Services (HHS). The HHS website is www.hhs.gov/ocr/privacyhowtofile.htm or you may call 1-866-627-7748.

Any alleged violation must have occurred on or after April 14, 2003. Complaints to the MTF HIPAA Privacy Officer or TMA Privacy Officer must :

(1) Be made in writing (electronic messages will not be accepted).

(2) Name the Military Treatment Facility that is the subject of the complaint.

(3) Describe the act(s) or omission(s) believed to be in violation of the applicable requirements of the HIPAA Privacy rule or MHS Notice of Privacy Practices.

(4) Be filed within 180 days of when you knew that the act or omission occurred. The above information may be communicated by letter, or by completing and signing the attached Health Information Privacy Complaint Form. You should send your letter or completed form to the Military Treatment Facility where the alleged violation took place or to the TMA Privacy Officer as appropriate. The TMA Privacy Office address is TRICARE Management Activity, Privacy Office, Five Skyline Place, Suite 810, 5111 Leesburg Pike, Falls Church, Virginia 22041-3206. You will be contacted in writing and notified of either the results of the investigation of your complaint, or that additional time will be required to fully examine the issue and respond.

Health Information Privacy Complaint Form

Before completing this form, please read the attached FACT SHEET. Further questions may be directed to your local Military Treatment Facility Privacy Officer

Filing a complaint with Naval Health Care New England (NHCNE) is voluntary. However, without the information requested NHCNE may be unable to proceed with your complaint. We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974. Names or other identifying information about individuals are disclosed when it is necessary for investigation of information outside the Military Health System/TRICARE for purposes associated with health information privacy compliance and as permitted by law. It is illegal for a covered entity to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the HIPAA Privacy Rule.

- INSTRUCTIONS -

If you are filing a compliant on your own behalf, complete Sections A and C. If you are filing a compliant on behalf of someone else, complete A, B, & C. Provide your information in Section A and information on the person whose rights may have been violated in Section B.

- Section A-

Last Name	First Name	Middle Initial	Suffix
Work Phone	Home Phone	E-Mail Address	
Street Address	City, State, Zip Code		

- Section B-

Last Name	First Name	Middle Initial	Suffix
Work Phone	Home Phone	E-Mail Address	
Street Address	City, State, Zip Code		

- Section C-

Relationship to Patient

What NHCNE facility or other treatment facility do you believe violated your (or someone else's) health information privacy rights or committed another violation of the HIPAA Privacy Rule?
Name of Military Treatment Facility and or Facility location:

When do you believe that the violation of health information privacy rights occurred? List Date(s)

Describe what happened. How and why do you believe your (or someone else's) health information privacy rights were violated, or the Privacy Rule otherwise was violated? Please be as specific as possible. (Attach additional pages if needed)

SIGNATURE_____ DATE _____

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The remaining information on this form is optional. Failure to answer these voluntary questions will not affect NHCNE's decision to process your complaint.

Do you need special accommodations for us to communicate with you about this complaint (check all that apply)?

- o Braille
- o Large Print
- o Electronic Mail TTY
- o Foreign Language Interpreter (specify language)
- o Sign Language Interpreter (specify language)
- o Other

If we cannot reach you directly, is there someone we can contact to help us reach you?

Last Name	First Name	Middle Initial	Suffix
Work Phone	Home Phone	E-Mail Address	
Street Address	City, State, Zip Code		

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed.)

Person/Agency/Organization/ Court Name(s)

Date (s) Filed	Case Number (s) (if known)